

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047157

6504

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No. 1062

Registrar's No.

FILED JAN 7 1963

VS 300
Rev. 4/59

1

2 3028

3

4 0

5 9

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7 9

8 0

9 4200

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11

12 72-3

13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

BY ADELAID OF H. OWENS MEDICAL CERTIFICATION

1. PLACE OF DEATH

a. COUNTY

Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN Kansas City

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

Jackson

c. CITY OR TOWN

Kansas City

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION D.O.A. General Hospital

Inside Limits

Yes ☐ No ☒

d. STREET ADDRESS (If outside, give location)
523 Grand

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

First

JOHN

Middle

HENRY

Last

RIEG

4. DATE OF DEATH

Month

Dec.

Day

16-

Year

1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married

Widowed ☐

8. DATE OF BIRTH

2/9/1893

9. AGE (last birthday)

69

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

K.C. Mo.

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic heart disease

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from _____, to _____ and last saw her alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

M.D. Coroner

22b. ADDRESS

152 Union Station

22c. DATE SIGNED

12-20-62

23a. BURIAL, CREMATION, OR OTHER FINAL DISPOSITION (Specify)

23b. DATE

12-20-62

23c. NAME OF CEMETERY OR CREMATORY

K.C. college of Osteopathy

23d. LOCATION (City, town, or county)

K.C. Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Lapetina Funeral Home

538

Campbell

25. DATE RECD. BY LOCAL REG.

12-20-62

26. REGISTRAR'S SIGNATURE

Ruth Long

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

~~as by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jack F. Moon

Licensed Embalmer No. 4729

P. O. Address Trinkle, Mo.

Note: The above; MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.